FORM 1R
REINSTATEMENT
REVOKED LICENSE

ALABAMA BOARD OF NURSING

RSA PLAZA SUITE 250
770 WASHINGTON AVENUE
MONTGOMERY, AL 36130-3900
TELEPHONE: 334-242-4060

OFFICE USE ONLY

Application Complete

____/____/____

APPLICATION FOR REINSTATEMENT OF A NURSING LICENSE

(PRINT OR TYPE ALL INFORMATION)

PART A – GENERAL INFORMATION

NAME:_____ SOCIAL SECURITY NUMBER: _ _ _ - _ _ - _ _ _ _
Last First Middle

STATE ANY OTHER NAMES OR ALIASES YOU HAVE BEEN KNOWN BY:_____ DATE OF BIRTH:_____/_____/_____
Mo. Day Yr.

LEGAL MAILING ADDRESS: _____ TELEPHONE (_ _ _) _ _ _ - _ _ _ _
Box or Street

_____ TELEPHONE (_ _ _) _ _ _ - _ _ _ _
City State Zip Code

PROFESSION: Registered Nurse _____ Alabama RN License No: 1-_ _ _ _ _ _ DATE ISSUED: ____/____/____
Mo. Day Yr.

Licensed Practical Nurse _____ Alabama LPN License No: 2-_ _ _ _ _ _ DATE ISSUED: ____/____/____
Mo. Day Yr.

Are you represented by an attorney in this matter? O YES O NO If yes, state name, address and telephone number below:

_____ (_ _ _) _ _ _ - _ _ _ _
Attorney Name Address City State Zip Code Telephone

PART B – GENERAL QUESTIONS

1. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? O YES O NO

2. Are there any pending criminal charges against you? O YES O NO

3. Have you ever had charges brought against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country other than Alabama? O YES O NO

4. Has any licensing authority imposed any disciplinary action against your license other than Alabama? O YES O NO

5. Have you ever been requested to appear before or submit an explanation to any licensing authority in regard to any charges or complaints other than Alabama? O YES O NO

6. Have you ever been denied a license or the opportunity to take an examination for licensure by any licensing authority other than Alabama? O YES O NO

7. Has any hospital or any other health related facility/agency restricted or terminated your professional training, employment or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? O YES O NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER FOR EACH ITEM. YOU MUST INCLUDE ANY CERTIFIED DOCUMENTATION FOR EACH ITEM.

8. Have you ever received counseling or treatment connected with the revocation/surrender/suspension/denial of your license? If yes, attach a copy of the admission and discharge summaries from the Board-recognized Treatment Provider and a statement from the treating practitioner/facility regarding your current diagnosis and prognosis, including your ability to resume the practice of nursing, and an executed release from each practitioner or facility. (Form 2R) O YES O NO

9. If the license to practice nursing was revoked/relinquished due to drug/alcohol-related matters, complete the following requested information for each counseling or treatment received:

FROM MONTH-YEAR	TO MONTH-YEAR	TYPE OF TREATMENT	PLACE & ADDRESS OF TREATMENT

PART C – COMMUNITY SERVICE (OPTIONAL UNLESS COURT ORDERED)

List any community or public service related activities you have been involved in since the date of the revocation/surrender/suspension/denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

TYPE OF ACTIVITY	NAME OF ORGANIZATION	DATE(S)	NUMBER OF HOURS

PART D – CONTINUING EDUCATION

1. List continuing education credits you earned since the revocation/surrender/suspension/denial of your license on the attached form. You must **submit proof of 24 contact hours of CE obtained within the past 24 months.**

2. List other methods, if any, that you have used to maintain/improve your knowledge and skill in the practice of your profession since the date of revocation/surrender/suspension/denial of your license. If additional space is required, attach a separate list.

3. Explain how the education preparation (listed in items 1 & 2 above) is relevant to the specific conduct that resulted in the loss of your license.

PART E – LICENSURE STATUS

1. Are you licensed or have you ever held a nursing or health related license in any other state or country? O YES O NO

   If yes, list each jurisdiction. A Verification of Licensure in Another Jurisdiction (Form 3R) must be received for each license (including all inactive licenses) listed.

State or Country	Profession	Date License Issued	Any Limitations on License	If License is not Current, Explain Below or On Separate Sheet

2. Have you ever held or do you currently hold an Alabama license in another profession? O YES O NO

   If yes, complete section below.

Profession	License Number	Date of Licensure	Current Status

PART F – EMPLOYMENT HISTORY

List all employment chronologically since graduation from your nursing school to the present. Explain periods of unemployment. If additional space is required, attach a separate sheet. Begin with date of graduation from your nursing school and end with the present date.

FROM Month - Year	TO Month - Year	REASON FOR EMPLOYMENT TERMINATION / RESIGNATION	Employers
			Employer: Address: Position held: Telephone (_ _ _ - _ _ _ - _ _ _ _ Duties:
			Employer: Address: Position held: Telephone (_ _ _ - _ _ _ - _ _ _ _ Duties:
			Employer: Address: Position held: Telephone (_ _ _ - _ _ _ - _ _ _ _ Duties:
			Employer: Address: Position held: Telephone (_ _ _ - _ _ _ - _ _ _ _ Duties:
			Employer: Address:

			Position held: Duties:	Telephone (_ _ _ - _ _ _ - _ _ _ _

PART G – PROFESSIONAL REHABILITATION ACTIVITIES

List any professional practice-related rehabilitation activities (Aftercare, 12-step meetings, support groups, etc) which you have undertaken to address the action(s) which resulted in the loss or denial of your license. Submit supporting documentation for each activity listed. If additional space is required, attach a separate sheet.

FROM Month-Year	TO Month-Year	Activity	Frequency

PART H – SUBMISSION OF AFFIDAVITS

An application for reinstatement will not be considered complete without at least 5 notarized supporting affidavits (Form 4R) attached. The supporting affidavits must be from individuals who are not related to you and have direct knowledge of the reasons for the loss or denial of your license and can testify regarding your fitness to return to the safe practice of nursing. List the names and telephone numbers of the individuals for which you have attached affidavits. If additional space is required, attach a separate sheet. Include the required affidavits, in separate sealed and signed envelopes along with this application.

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

PART I – CERTIFICATION

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

_____ _____

Signature of Petitioner Date

Sworn to before me this _____ day of _____ _____

_____

Signature of Notary

RETURN TO: Alabama Board of Nursing, P.O. Box 303900, Montgomery, AL 36130-3900

FORM 2R
REINSTATEMENT
REVOKED LICENSE

ALABAMA BOARD OF NURSING

RSA PLAZA SUITE 250
770 WASHINGTON AVENUE
MONTGOMERY, AL 36130-3900
TELEPHONE: 334-242-4060

This form is to be completed ONLY by applicants who answered "YES" to question #9 in Part B of Form 1R

AUTHORIZATION TO RELEASE TREATMENT RECORDS

INSTRUCTIONS: If you answered "Yes" to question #9 in Part B of the Application Form 1R, you must complete a separate authorization form for each professional practitioner and/or hospital/facility where you have been treated. If additional forms are needed, this form may be photocopied. DO NOT MAIL THIS AUTHORIZATION SEPARATELY. Completed authorizations must be attached to your application for reinstatement.

I, (print your name here) _____, request and authorize the **below-named** licensed professional or practitioner or the **below-named** hospital or facility, to disclose fully to the Alabama Board of Nursing and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional practitioner, hospital or facility. I understand that this consent may be withdrawn by me at any time except to the extent that the action has been taken in reliance upon it. In any event, this consent shall expire when the Alabama Board of Nursing has taken final action on my petition for reinstatement of my license. I also understand that my disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Name of practitioner_____ License No. _____

or

Name of hospital or other facility_____

Signature of petitioner _____ Date _____

October 2004
Form 2R

FORM 3R
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ALABAMA BOARD OF NURSING

RSA PLAZA SUITE 250
770 WASHINGTON AVENUE
MONTGOMERY, AL 36130-3900
TELEPHONE: 334-242-4060

This form is to be completed ONLY by applicants who are or have been licensed in another jurisdiction.

APPLICANT INSTRUCTIONS

1. Complete Sections I and II. Enter your name as it appears on your Application Form 1R.
2. DO NOT RETURN THIS FORM WITH YOUR APPLICATION. Send this form to each state or country where you are or have ever been licensed and request that they complete Section III on back. Be sure to include any fee(s) required. If additional forms are needed, this form may be photocopied. You must provide Verification of Licensure and the status of your license from ALL jurisdictions where you are or have ever been licensed. Verifications must be in English or otherwise submitted with an official translation.

SECTON I: APPLICANT INFORMATION

1. SOCIAL SECURITY NUMBER ☐☐☐ ☐☐ ☐☐☐☐ 2. BIRTHDATE ☐☐ ☐☐ ☐☐
MO. DAY YR.

3. FULL NAME LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MIDDLE ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. ADDRESS STREET ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CITY ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

STATE ☐☐ ZIP CODE ☐☐☐☐☐ ☐☐☐☐

5. NAME OF JURISDICTION _____ DATE OF LICENSURE ☐☐ ☐☐ ☐☐
MO. DAY YR.

_____
NAME UNDER WHICH YOU ARE OR WERE LICENSED IN THAT JURISDICTION

LICENSE NUMBER _____ PROFESSION _____

SECTION II: APPLICANT RELEASE

I request and authorize the above named jurisdiction to release any and all information pertaining to my license, including but not limited to, disciplinary actions and pending charges.

SIGNATURE OF APPLICANT _____ DATE _____

JURISDICTION'S CERTIFICATION IS TO BE COMPLETED ON REVERSE SIDE

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SECTION III: OTHER JURISDICTION'S CERTIFICATION. To be completed by the licensing authority. Do not return to applicant. Return completed form directly to: Alabama Board of Nursing, P. O. Box 303900, Montgomery, AL 36130-3900

1. a. Has the applicant named in Section I been subject to any disciplinary action? O YES O NO

   b. Are any charges pending against this individual? O YES O NO

   If the answer to either of these questions is "yes," please attach certified copies of all relevant information.

2. LICENSE NUMBER _____ DATE ISSUED ☐☐ ☐☐ ☐☐
   MO. DAY YR.

   Expiration of most recent registration ☐☐ ☐☐ ☐☐ Is the license current? O YES O NO
   MO. DAY YR.

   I certify that the information shown above is true and correct, according to the records of this office.

   Name of Jurisdiction: _____

   Name: _____

   Title: _____

   Signature: _____

   Date: _____

   Telephone Number: (_ _ _) _ _ _ - _ _ _ _

   FAX Number: (_ _ _) _ _ _ - _ _ _ _

SECTION IV: OPTIONAL COMMENTS. To be completed by the licensing authority.

Comments _____

_____

_____

_____

_____

_____

_____

_____

_____

Return completed form directly to:
ATTN: Legal Division
Alabama Board of Nursing, P.O. Box 303900, Montgomery, AL 36130-3900
Telephone: (334-242-4321

FORM 4R
REINSTATEMENT
REVOKED LICENSE

ALABAMA BOARD OF NURSING
RSA PLAZA SUITE 250
770 WASHINGTON AVENUE
MONTGOMERY, AL 36130-3900
TELEPHONE: 334-242-4060

SUPPORTING AFFIDAVIT

INSTRUCTIONS

APPLICANT: Complete items A and B and provide a copy to each of your affiants/references. Attach completed original of each affidavit to your reinstatement application.

AFFIANT/REFERENCE: Complete items 1 – 5, sign the affidavit in the presence of a notary public, and return the form in a sealed envelope signed by you to the applicant.

In the Matter of the Application of

A. _____
(Applicant's Name)

for the reinstatement of his/her license to practice as a

B. _____
(Type of License)

in the State of Alabama.

This affidavit is in support of an application for reinstatement of a nursing license.

State of_____)
) §:
County of _____)

_____, being duly sworn deposes and says:

1. My name is _____.
(affiant/reference name)

I reside at _____.
(affiant/reference address)

My daytime telephone number (include area code) is _____.

My occupation is _____.

I am a licensed professional O YES O NO

If yes, Profession: _____ State: _____

License Number: _____Is the license current? O YES O NO

Date License Issued: _____/_____/_____ Expiration Date of Last Registration: _____/_____/_____

I am of sound mind, capable of making this affidavit and personally acquainted with the facts stated herein.

I make this affidavit in support of _____application for reinstatement

of (his/her) license to practice as a _____ in the State of Alabama.

2. I have known the applicant for _____ years and _____ months through the following contacts:

_____

_____

_____

3. It is my understanding that the applicant's license was revoked, surrendered, suspended or denied because (provide a detailed statement of circumstances which led to revocation/surrender/suspension/denial of license):

_____

_____

_____

_____

4. It is my understanding that the applicant has undertaken the following activities to rehabilitate (himself/herself) (provide a detailed statement of activities):

_____

_____

_____

_____

5. I recommend that the applicant's license be reinstated because:

_____

_____

_____

_____

_____
(Signature of Affiant/Reference)

Sworn to before me this _____day of _____ _____.

Notary Public_____

My commission expires _____ _____, _____

"√ " IF INDEPENDENT STUDY	COURSE/SEMINAR ATTENDED	DATE(S) OF ATTENDANCE	CREDIT/CONTACT HOURS